



**HEARING PROFESSIONALS**  
DOCTORS OF AUDIOLOGY  
PERSONALIZED HEARING CARE & BALANCE CENTER

# Medical History

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

1. What is the reason for today's visit?
2. Will this be your first hearing test? [ ] Yes [ ] No
3. Have you ever had ear surgery? [ ] Yes [ ] No
4. Do you have any of the following:
  - a. Deformity of the ear? [ ] Yes [ ] No
  - b. Recent ear drainage? [ ] Yes [ ] No
  - c. Ear infection? [ ] Yes [ ] No
5. Do you feel that your hearing is worse in one ear? [ ] Yes [ ] No
  - a. If so, which ear is worse? [ ] Left [ ] Right
6. Do you experience noises or sounds in your ears? [ ] Yes [ ] No
7. Have you had sudden or rapid hearing loss in the past 90 days? [ ] Yes [ ] No
8. Have you experienced acute or recurring dizziness? [ ] Yes [ ] No
9. Is there a family history of hearing loss? [ ] Yes [ ] No
10. Do you ever have ear pain? [ ] Yes [ ] No
11. Have you ever found it necessary to have a doctor remove wax from your ears? [ ] Yes [ ] No
12. Have you been exposed to loud sounds at work or in hobbies? [ ] Yes [ ] No
13. Do you experience sensations of fullness in the ears? [ ] Yes [ ] No
14. Do you have diabetes or high blood pressure problems at this time? [ ] Yes [ ] No
15. Do you have any medical conditions that we should be aware of? [ ] Yes [ ] No
16. Are you on any medications? [ ] Yes [ ] No
  - a. If so, please list: \_\_\_\_\_
17. What hearing difficulties are you experiencing? \_\_\_\_\_
18. If you are fortunate enough to be helped, are you prepared today to continue on a program for better hearing, which may include the use of hearing aids? [ ] Yes [ ] No
19. In what situations would you like to hear better? \_\_\_\_\_
20. What would prevent you from wearing hearing aids? \_\_\_\_\_
21. How did you hear about Hearing Professionals? \_\_\_\_\_

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